U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 21 November 2005

Case No.: 2004-BLA-5528

In the Matter of:

McCRAY AMBURGEY
Claimant

v.

JONES FORK OPERATION
Employer

CONSOL ENERGY INC.
Carrier

and

DIRECTOR,OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

James D. Holliday, Esq.
For the Claimant

Natalee Gilmore, Esq.
For the Employer

BEFORE: JOSEPH E. KANE,
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS

This proceeding arises from a claim for benefits under 30 U.S.C. §§ 901-945. In accordance with the Act and regulations issued thereunder, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awardable to persons who are totally disabled within the meaning of the Act due to pneumoconiosis. Benefits are also awardable to the survivors of persons whose death was caused by pneumoconiosis, and for claims filed prior to January 1, 1982, to the survivors of persons who were totally disabled from pneumoconiosis at the time of

the deaths. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment. It is commonly known as black lung.

A formal hearing was held before the undersigned on April 6, 2005, in Hazard, Kentucky at which all parties were afforded full opportunity, in accordance with the Rules of Practice and Procedure (29 C.F.R. Part 18), to present evidence and argument as provided in the Act and the regulations issued thereunder, set forth in Title 20, Code of Federal Regulations, Parts 410, 718, 725, and 727. Claimant and Employer were represented by counsel. No appearance was entered on behalf of the Director, Office of Workers' Compensation Programs. Subsequent to the hearing, pursuant to agreement at the hearing, Employer submitted the transcript of a deposition of Dr. L. Repsher, dated April 21, 2005 which is hereby entered into evidence as Employer's Exhibit 6[1].

Issues

At the hearing, the Employer agreed Claimant has established 18 years of coal mine employment. That stipulation is supported by the miner's Social Security Administration Earnings Statement (DX 7). The following issues remain for resolution:

(1) Whether the claim was timely filed;

(2) Whether Claimant has pneumoconiosis;

(3) Whether Claimant's pneumoconiosis arose out of coal mine employment;

(4) Whether Claimant is totally disabled; and

(5) Whether the Claimant's total disability is due to his coal workers' pneumoconiosis.

Background History

Claimant married Pauline Handshoe on January 23, 1960 and they have one child, Travis McCray Amburgey, born on December 31, 1992 (DX 1, 9, TR 15). These two are Claimant's dependents for purposes of benefit augmentation. Claimant testified he worked for eighteen years at the face in underground mining. He ran scoops, roof bolters and a wagon drill. He worked in coal seams from 26 inches to 42 or 43 inches high (TR 11-12). Claimant ceased coal mine employment when he began having panic attacks on October 28, 1993 (DX 1, TR 13). Claimant had previous back surgery in 1994. Claimant has received Social Security Disability since 1996 due to his back problems.

Claimant was born on September 3, 1957 and he was 47 years old at the time of the hearing. He went to school through the 8th grade (DX 1). Claimant testified he gets short of breath on minimal exertion. He began smoking at the age of 15 and has smoked for over 30

[1] DX indicates Director's Exhibits; EX indicates Employer's Exhibits; CX indicates Claimant's Exhibits; and TR indicates the transcript of the hearing held on April 6, 2005.

years, up to two packs a day . Claimant is currently trying to quit smoking (TR 18). Claimant is treated by Dr. Potter and Dr. Sikder (TR 16). These physicians have prescribed medications and an inhaler for his breathing problems (Tr 13-14).

Claimant filed this claim on November 25, 2002 and it is his first claim for benefits under the Act (DX 2). The regulations at 20 C.F.R. § 725.308 provide that a claim for benefits shall be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner. The regulations also provide a rebuttable presumption that every claim for benefits is timely filed. No evidence was submitted to rebut this presumption. I find, therefore, this claim was timely filed.

Applicable Regulations

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. 20 C.F.R. §§ 718.202-718.205. The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP,* 9 B.L.R. 1-1 (1986).

Presence of Pneumoconiosis

Pursuant to Section 718.202, a living miner can demonstrate the presence of pneumoconiosis by: 1) x-rays interpreted as being positive for the disease; or 2) biopsy evidence; or 3) the presumptions described in Sections 718.304, 718.305, or 718.306, if found to be applicable; or 4) a reasoned medical opinion which concluded the disease is present, if the opinion is based on objective medical evidence such as blood-gas studies, pulmonary function studies, physical examinations, and medical and work histories.

Chest X-ray Reports

EX. NO.	DOCTOR CRDNTL[2]	DATE OF X-RAY	READING
DX 14	G. Baker, B	01-15-03	0/1 p, p, emphysema
DX 14	Goldstein, B/BCR	01-15-03	Quality reading only – Quality 1
EX 1	Wiot, B/BCR	01-15-03	No pneumoconiosis, emphysema
EX 1	Wiot, B/BCR	01-15-03	No pneumoconiosis, emphysema
CX 1	Alexander, B/BCR	01-15-03	1/0 p, p, emphysema

[2] The symbol "B" denotes a physicians who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a radiologist who has demonstrated his expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. §37.51 (1982). The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. §727.206(b)(2)(III).

EX. NO.	DOCTOR CRDNTL[3]	DATE OF X-RAY	READING
EX 2	Repsher, B	01-22-04	No pneumoconiosis, emphysema
CX 3	Alexander, B/BCR	01-22-04	1/0 p, p, emphysema
EX 3	Rosenberg, B	02-16-04	No pneumoconiosis, emphysema
CX 4	Alexander, BCR/B	02-16-04	1/0 p, p, emphysema
CX 2	Alexander, BCR/B	08-19-04	1/0 p, p, emphysema
EX 7	Wiot, BCR/B	08-19-04	No pneumoconiosis, emphysema

The record includes positive readings and negative readings of the four of the five chest x-ray films of record. The earlier film, taken on January 15, 2003 was read negative by the two readers who read this film. The January 15, 2003 and August 19, 2004 x-ray films were read by the two physicians, Drs. Wiot and Alexander, who are both dually qualified as board certified radiologists and B-readers. These equally credible readings by the highly qualified physicians reach opposite results. Similarly, Dr. Alexander found the January 22, 2004 and February 16, 2004 chest x-ray film positive, while Drs. Repsher and Rosenberg, highly qualified as pulmonary specialists and B-readers, found these x-ray films negative for pneumoconiosis. I find, therefore, that the x-ray evidence is evenly balanced. Under such circumstances, when the evidence is evenly balanced, the benefits claimant must lose since he bears the burden of persuasion. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 11 S.Ct. 2251 (1994). Thus, I find Claimant has not established the presence of pneumoconiosis by the x-ray reports of record under the provisions of subsection 718.202(a)(1).

Biopsy Evidence and Presumptions

Claimant has not established pneumoconiosis by the provisions of subsection 718.202 (a)(2) since no biopsy evidence has been submitted into evidence. Likewise, since none of the presumptions are applicable to his claim he has not established pneumoconiosis by the provisions of subsection 718.202(a)(3).

Medical Opinion Reports

The final way to establish the existence of pneumoconiosis under Section 718.202(a) is set forth in subparagraph (a)(4). A determination of the existence of pneumoconiosis may be made, notwithstanding a negative x-ray, if a physician exercising sound medical judgment finds the miner suffers from pneumoconiosis as defined in §718.201. Any such finding shall be based on objective medical evidence, such as arterial blood gas tests, physical performance tests,

[3] The symbol "B" denotes a physicians who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a radiologist who has demonstrated his expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. §37.51 (1982). The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. §727.206(b)(2)(III).

physical examinations, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion. The record includes the following medical opinion reports:

Dr. G. Baker, a pulmonary specialist, examined Claimant on January 15, 2003. Dr. Baker reported normal findings on physical examination. He also reported pneumoconiosis, 0/1 on chest x-ray, moderate obstructive defect on pulmonary function study and mild resting arterial hypoxemia on blood gas study. On electrocardiogram testing, Dr. Baker reported normal sinus rhythm. Dr. Baker concluded Claimant has: 1) chronic obstructive pulmonary disease with moderate obstructive defect based on pulmonary function study results; 2) chronic bronchitis based on Claimant's history of cough, sputum production and wheezing; and 3) hypoxemia based on Claimant's blood gas study results. Dr. Baker also stated Claimant has a moderate impairment due to cigarette smoking and coal mine dust exposure. In answer to questions, he stated Claimant does have an occupational lung disease caused by coal mine dust exposure and he does not retain the capacity to do his usual coal mine employment based on the low FEV-1 values (DX 14). On May 9, 2003, Dr. Baker stated Claimant's chronic dust disease of the lungs is due to coal mine dust exposure based on the fact he is a miner with obstructive airway disease secondary to coal mine dust exposure in the absence of chest x-ray changes of pneumoconiosis. Dr. Baker stated he relied upon Claimant's history of coal mine dust exposure, pulmonary function study results, decreased arterial pO2, history of chronic bronchitis, findings on clinical examination of the chest and the miner's medical history in reaching this conclusion (DX 11).

At a deposition taken on February 3, 2005, Dr. Baker reiterated his findings that Claimant has chronic obstructive airway disease with a moderate obstructive defect as demonstrated by pulmonary function study results, chronic bronchitis, and the arterial hypoxemia. Dr. Baker stated the etiology of this obstructive airway disease is both Claimant's history of coal mine dust exposure and his history of smoking cigarettes. Dr. Baker noted the medical literature has established that one cause of obstructive airway disease is coal mine dust exposure. He also stated Claimant would have difficulty performing work as a roof bolter based on his obstructive airway disease. Dr. Baker disagreed with Dr. Repsher's statement that coal worker's pneumoconiosis when clinically significant is primarily a restrictive disease. Dr. Baker stated the medical literature shows coal worker's pneumoconiosis is primarily an obstructive disease. Dr. Baker disgreed with Dr. Rosenberg's statement that the lack of chest x-ray evidence of coal worker's pneumoconiosis establishes that the chronic obstructive pulmonary disease present is not caused by coal mine dust exposure. Dr. Baker reiterated his finding that Claimant has "legal pneumoconiosis" and he is totally disabled due to his pulmonary condition which is due to both coal mine dust exposure and cigarette smoking. Dr. Baker noted that only 15% of people who smoke get emphysema or chronic bronchitis, thus, not everyone is susceptible to the effects of cigarette smoke. He stated people who are susceptible to cigarette smoke are probably susceptible to another exposure like coal mine dust. He stated there is no way to medically prove which agent caused the obstructive disease. Dr. Baker agreed that the miner's obstructive impairment could be due totally to cigarette smoke or it could be due totally to coal mine dust exposure. He stated that since there is no way to determine the difference, it is reasonable to attribute it to both causes. Dr. Baker noted that certain people have a genetic predisposition to get obstructive airway disease from exposure to cigarette smoke, coal mine dust, environmental agents, fumes from factories, fumes from cars and similar exposure (CX 6).

Records from Dr. I. Potter, Claimant's treating physician, were submitted, most of which were handwritten and illegible. Dr. Potter treated Claimant from March 15, 1994 through April 22, 2003 for chronic obstructive pulmonary disease and chronic obstructive airways disease. A report dated June 3, 2002 noted chronic interstitial changes, medications were pre-scribed and additional tests were scheduled. The chest x-ray reading by Dr. M. Pampati found chronic obstructive pulmonary disease with no acute infiltrate. Earlier chest x-ray readings noted by Dr. Potter on March 15, 1994 reported scattered interstitial changes consistent with coal worker's pneumoconiosis, some calcification of the aorta, including one by Dr. Datu on December 12, 2000 reporting no active lung disease and one by Dr. A. Patel on January 21, 2002 reporting no active disease (DX 13). On a questionnaire dated May 23, 2003, Dr. Potter stated he diagnosed occupational lung disease based on chest x-ray changes. He concluded Claimant has medical pneumoconiosis and he stated the presence of legal pneumoconiosis is still to be determined (referring, apparently, to the claim's process rather than the more technical regulatory definition of legal pneumoconiosis). Dr. Potter stated Claimant has a moderate impairment which is related to pneumoconiosis and his history of smoking. Dr. Potter concluded Claimant does not retain the respiratory capacity to do his coal mine employment based on the significant decrease in respiratory function. The chronic obstructive pulmonary disease and coal worker's pneumoconiosis combine and form a significant disability (DX 12).

Treatment records from Dr. A. Sikder were submitted. In a consultation dated November 4, 2004, Dr. Sikder reported fair exchange bilaterally on physical examination of the lungs with no rales or rhonchi. Dr. Sikder reported severe hyperinflation on chest x-ray dated August 24, 2004 and overall mild obstructive airway disease with no bronchodilator response on pulmonary function study. Dr. Sikder diagnosed: 1) chronic obstructive pulmonary disease, stage 2; 2) rheumatoid arthritis; 3) degenerative joint disease; 4) tobacco abuse; and 5) sinusitis. She noted the chest x-ray showed no evidence of rheumatoid lung. In a follow-up visit on November 11, 2004, Dr. Sikder noted emphysema or a differential diagnosis of interstitial lung disease was present. In addition, additional tests were being conducted to determine if the rheumatoid arthritis was the cause of Claimant's chest pain (EX 4).

Dr. L. Repsher, a pulmonary specialist, examined Claimant on January 22, 2004 and reported normal results on physical examination. Dr. Repsher reported no evidence of coal worker's pneumoconiosis on chest x-ray, but he stated there was evidence of emphysema on chest x-ray. On pulmonary function study, he reported moderately severe chronic obstructive pulmonary disease without significant response to bronchodilators. Dr. Repsher also reported a normal diffusing capacity which he stated ruled out significant interstitial lung disease such as coal worker's pneumoconiosis. Dr. Repsher also reported normal results on blood gas study. On carboxyhemoglobin testing, Claimant's values were elevated demonstrating a 1 1/2 pack a day smoking habit. Dr. Repsher also reviewed the records. He concluded Claimant does not have coal worker's pneumoconiosis or any other pulmonary or respiratory impairment or disability caused by or aggravated by coal mine employment. Dr. Repsher based his conclusion on: 1) the absence of chest x-ray evidence of pneumoconiosis; 2) the pulmonary function study results which showed no evidence of coal worker's pneumoconiosis since they demonstrated a pure obstructive disease characteristic of smoking and chronic obstructive pulmonary disease. Dr. Repsher stated that when coal worker's pneumoconiosis is clinically significant is it primarily a restrictive disease which may have some obstructive features; 3) there is no blood gas evidence

of coal worker's pneumoconiosis; and 4) Claimant has chronic obstructive pulmonary disease which is due to his cigarette smoking and which is not related to coal mine dust exposure (EX 2).

At a deposition taken on March 13, 2004, Dr. Repsher stated he did agree coal mine dust exposure could cause very mild chronic obstructive pulmonary disease, but that it would probably reverse within six to twelve months of ceasing coal mine employment, although he also agreed this did not always happen. Dr. Repsher stated the medical data shows that statistically there is a significant presence of chronic obstructive pulmonary disease in miners, but the same data shows this chronic obstructive pulmonary disease is not clinically significant. Dr. Repsher reiterated his earlier statement that the normal diffusion capacity rules out significant interstitial disease. He stated his opinion that coal mine dust exposure was not responsible for the chronic obstructive pulmonary disease present was based on the negative chest x-ray. On further questioning, he stated that obstruction due to coal mine dust exposure could be established only if a patient was a non-smoker and did not have asthma. Otherwise, even with the presence of chest x-ray changes of 0/0 to 3/3, only about 1% of the patients have a pulmonary disability due to coal mine dust exposure. On cross-examination, Dr. Repsher stated the medical articles that purport to show that you can get clinically significant airways obstruction from coal mine dust exposure do not support that conclusion. Dr. Repsher stated it was his opinion the definition of "legal pneumoconiosis" was possible, but the medical literature has not really documented that it occurs. He reiterated his opinion that the possibility would be less than one percent (EX 10).

At a more recent deposition, taken on April 1, 2005, Dr. Repsher reviewed the results of CT scans. He stated they showed evidence of cigarette smoke induced chronic obstructive pulmonary disease, cigarette smoke aggravated arteriosclerosis, and evidence of coronary artery disease. He stated there was no evidence of coal mine dust exposure. Dr. Repsher disagreed with Dr. Alexander's x-ray readings. Dr. Repsher stated on review of Dr. Sikder's report, she was assessing whether or not Claimant's pulmonary function was affected by methotreaxate, a medication Claimant was taking for rheumatoid arthritis. Dr. Repsher discounted Dr. Baker's opinions and interpretation of medical articles. Dr. Repsher stated in particular there are no medical articles which show that a patient susceptible to cigarette smoke is also susceptible to coal mine dust. Dr. Repsher stated again that to establish a clinically significant chronic obstructive pulmonary disease from coal mine dust exposure one would need to have a non-smoking miner to demonstrate that fact scientifically. He agreed it is possible for coal mine dust exposure by itself to cause a disabling respiratory impairment, but he stated he has never seen such a case (EX 9).

Dr. D. Rosenberg, a pulmonary specialist, examined Claimant on February 16, 2004 and reported equal expansion with hyperresonance, scattered wheezes and decreased breath sounds on physical examination. On chest x–ray, Dr. Rosenberg reported no evidence of coal worker's pneumoconiosis, but evidence of emphysema. Dr. Rosenberg stated carboxyhemoglobin testing showed a marked elevation, however, the blood gas testing showed normal oxygenation. On pulmonary function study, Claimant demonstrated a moderate to severe airflow obstruction with response to bronchodilators. Dr. Rosenberg stated that the total lung capacity value was elevated so Claimant has no evidence of restriction and the diffusing capacity values show the alveolar capillaries within the lungs are intact. Dr. Rosenberg stated the findings on physical examination were consistent with obstructive lung disease and the chest x-ray was negative. Based on all these findings, Dr. Rosenberg concluded the interstitial form of coal worker's pneumoconiosis is not present. From a functional perspective, Dr. Rosenberg stated Claimant is moderately to

severely impaired and, based on the airflow obstruction, Claimant could not do his usual coal mine employment. Dr. Rosenberg stated it was his opinion the airflow obstruction from the chronic obstructive pulmonary disease was not due to coal mine dust exposure since there is no evidence of coal worker's pneumoconiosis on chest x-ray (EX 3).

At a deposition taken on March 21, 2005, Dr. Rosenberg stated the carboxyhemoglobin test results are consistent with a smoking habit of one pack a day. Dr. Rosenberg stated Claimant's improvement on the use of bronchodilators is not consistent with coal worker's pneumoconiosis (EX 8).

Initially, I note that all the physicians, except Dr. Potter, concluded Claimant does not have medical pneumoconiosis since the chest x-ray evidence shows changes of chronic obstructive pulmonary disease and emphysema, but not changes of medical pneumoconiosis. Dr. Potter's opinion in this regard is outweighed by the opinions of Drs. Baker, Repsher and Rosenberg. The question of "legal pneumoconiosis", however, is not as clear. The regulatory definition of legal pneumoconiosis includes both chronic restrictive or obstructive pulmonary disease arising out of coal mine employment. 20 CFR § 718.201(2). Dr. Rosenberg's finding that the chronic obstructive changes present were not due to coal mine dust exposure was based primarily on his finding that there is no chest x-ray evidence of medical pneumoconiosis. He also noted the pulmonary test results demonstrated no interstitial form of coal worker's pneumoconiosis is present, but he did not explain why the pulmonary test results demonstrate no legal pneumoconiosis is present. Dr. Rosenberg did not offer any other explanation for why the chronic obstructive pulmonary disease which he agrees is present is not due to both cigarette smoking and coal mine dust exposure except for the negative chest x-ray. The regulations, however, do not require chest x-ray changes be present to establish legal pneumoconiosis under the provisions of Section 718.201(2). Thus, I find Dr. Rosenberg's conclusion that the chronic obstructive pulmonary disease present is not due to coal mine dust exposure and that pneumoconiosis is present only with a positive chest x-ray is in conflict with the regulations. In consideration of these factors, I accord less weight to Dr. Rosenberg's opinion that Claimant does not have pneumoconiosis and that Claimant's chronic obstructive pulmonary disease is not "legal" pneumoconiosis as defined in the regulations.

Dr. Repsher discussed his opinion that the miner's chronic obstructive pulmonary disease is not due to coal mine dust exposure in great detail at the two depositions. However, I find his opinion less persuasive. Dr. Repsher states that the medical literature does not establish any basis for the regulatory provision that an obstruction lung disease can be caused by coal mine dust exposure. In *Freeman United Coal Mining Co. v. Summers*, 272 F.3d 473 (7th Cir. 2001), the Seventh Circuit held under similar circumstances that the ALJ properly gave less weight to the opinions of a physician who stated, 'there is no good clinical evidence in the medical literature that coal dust inhalation in and of itself causes significant obstructive lung disease.' The Seventh Circuit noted that during a rulemaking proceeding, the Department of Labor considered a similar presentation and concluded that such an opinion is not in accord with the prevailing view of the medical community or the substantial weight of the medical and scientific literature. For similar reasons, I find Dr. Repsher's opinion that Claimant's chronic obstructive pulmonary disease is not due to coal mine dust exposure based on his opinion that the medical literature does not support the regulatory provision that an obstructive lung disease can be due to coal mine dust exposure to be entitled to less weight since it is not in accord with the regulations based on

the prevailing view of the medical community or the substantial weight of the medical and scientific literature.

I find the opinions of Drs. Repsher and Rosenberg fail to adequately explain why they conclude that the miner's coal mine dust exposure did not contribute to his chronic obstructive pulmonary disease, which all physicians agree is present. Since their opinions are based on the absence of findings of medical pneumoconiosis on chest x-ray and, in Dr. Repsher's report, his opinion that the regulations are not consistent with the medical literature, I accord less weight to these opinions.

I accord greater weight to Dr. Baker's opinion which is well supported by extensive medical reports to which he refers and which is consistent with the regulatory provisions. In addition, I note Dr. Baker is highly qualified as a pulmonary specialist. Accordingly, I find Dr. Baker's opinion outweighs the contrary medical opinion reports of record and is sufficient to establish the presence of pneumoconiosis under the provisions of Section 718.202(a)(4).

In addition to the evidence noted above, the record also includes three interpretations of CT scans. CT scans are admissible as other medical evidence pursuant to 20 C.F.R. § 107(a). All three physicians, Drs. Repsher, Scott, and Wheeler, who reviewed the CT scans agreed they showed no evidence of medical coal worker's pneumoconiosis. The physicians all agreed there was evidence of chronic obstructive pulmonary disease or emphysema. I also note Dr. Wheeler's statement that the CT scan was incomplete since only 10% of Claimant's lungs were scanned. Thus, I find the reports to be less persuasive since the CT scan reviewed only 10% of the miner's lungs. I find, however, similar to the discussion of the x-ray evidence, the CT scans are supportive of the finding that the miner does not have medical pneumoconiosis. There is nothing in these reports, however, that challenges Dr. Baker's finding that the chronic obstructive pulmonary disease present is due, at least in part, to Claimant's coal mine dust exposure (EX 5, 6).

On consideration of all of the evidence, I find Dr. Baker's report the most persuasive medical evidence of record. I note that Dr. Baker agreed there is no radiographic evidence of medical pneumoconiosis, however, based on his finding Claimant has chronic obstructive pulmonary disease and Dr. Baker's discussion of and reliance upon the medical literature which conclude that obstructive lung disease can be due to coal mine dust exposure, I find his conclusion that the miner's chronic obstructive pulmonary disease is due, in part, to coal mine dust exposure well supported and well reasoned. Therefore, I find his medical opinion report sufficient to establish the presence of pneumoconiosis under Section 718.202(a).

Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R § 718.203(b). The parties agreed Claimant worked eighteen years in coal mine employment. Since Claimant had more than ten years of coal mine employment, he receives the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. Although Drs. Repsher and Rosenberg concluded Claimant's chronic obstructive pulmonary disease was due

solely to his habit of smoking cigarettes, I find their opinions are entitled to less weight for the reasons set forth above. I find, therefore, their opinions are not sufficient to rebut the presumption that Claimant's legal pneumoconiosis arose out of his coal mine employment. Dr. Baker's opinion that Claimant's chronic obstructive pulmonary disease is due to both cigarette smoking and his exposure to coal mine dust exposure is supportive of the presumption. Therefore, I find Claimant has established his coal worker's pneumoconiosis arose out of his coal mine employment.

Total Disability

The determination of the existence of a totally disabling respiratory or pulmonary impairment shall be made under the provisions of Section 718.204. A claimant shall be considered totally disabled if the irrebuttable presumption of Section 718.304 applies to his claim. 20 CFR § 718.204(b)(1). If, as in this case, the irrebuttable presumption does not apply, a miner shall be considered totally disabled if he is prevented from performing his usual coal mine work or comarable and gainful work. In the absence of contrary probative evidence, evidence which meets one of the Section 718.204(b)(2) standards shall establish the claimant's total disability. According to Section 718.204(b)(2), the criteria to be applied in determining total disability include: 1) pulmonary function studies, 2) arterial blood gas tests, 3) a cor pulmonale diagnosis and 4) a reasoned medical opinion concluding total disability.

Pulmonary Function Studies

Pulmonary function study results were submitted for evaluation on the issue of total disability under Section 718.204(b)(2)(i). The pulmonary function study results are summarized in the table below:

EX. NO.	PHYSICIAN	DATE	AGE	FEV_1	FVC	FEV_1 FVC	MVV	QUALIFIES
DX 13	Potter	illegible	36	3.79	5.83	65.0%	133	no
DX 13	Potter	11-04-97	40	3.03	4.33	70.0%	120	no
				3.13	5.23	59.8%	121	no
DX 13	Potter	07-13-99	41	2.46	4.71	56%	96.5	no
				2.84	5.30	53%	109	no
DX 13	Potter	01-21-02	44	2.46	5.38	46%	---	yes
DX 14	Baker	01-15-03	45	2.49	5.63	44%	---	yes
DX 13		01-22-03	45	2.64	4.49	59%		no
				3.00	4.60	65%		no
EX 2	Repsher	01-22-04	46	2.19	4.66	47%	77	yes
				2.73	5.36	51%	103	yes
EX 3	Rosenberg	02-16-04	46	2.18	4.38	50%	81	yes
				2.56	5.06	51%	---	no

EX. NO.	PHYSICIAN	DATE	AGE	FEV_1	FVC	FEV_1 FVC	MVV	QUALIFIES
EX 4	Sikder	11-04-04	47	2.76	5.53	48%	---	no
				2.65	5.19	51%		no

I have assessed the results of the pulmonary function study considering a height of 72.5 inches based on a statement dated September 15, 2003, that the miner's height had been measured twice in his stocking feet and was 72.5 inches (DX 15). Claimant's values on the pulmonary function studies, including the values before and after the use of bronchodilators, vary from study to study. Since these studies show varying values, I find the pulmonary function study results are not sufficient, standing alone, to establish total disability under the provisions of subsection 718.204(b)(2)(i).

Arterial Blood Gas Studies

The record includes results from three blood gas studies. On January 15, 2003, Dr. Baker reported Claimant demonstrated an arterial pCO_2 of 38 and an arterial pO_2 of 76 at rest (DX 14). On January 22, 2004, Dr. Repsher reported an arterial pCO_2 of 38.4 and an arterial pO_2 of 79.2 at rest (EX 2). On February 22, 2004, Dr. Rosenberg reported Claimant demonstrated an arterial pCO_2 of 37.8 and an arterial pO_2 of 103.0 at rest. The physicians characterized these results as normal. Claimant's values on both these blood gas studies are non-qualifying under the regulations. Therefore, I find the blood gas study results do not establish that Claimant is totally disabled under the provisions of subsection 718.204(b)(2)(ii) .

Cor Pulmonale

A claimant may also establish total disability by providing medical evidence of cor pulmonale with right-sided congestive heart failure pursuant to Section 718.204(b)(2)(iii). As no medical evidence of cor pulmonale was admitted into the record, I find the Claimant failed to establish total disability with medical evidence of cor pulmonale.

Medical Opinions

The remaining means of establishing a totally disabling respiratory or pulmonary impairment under Section 718.204(b)(2) is with a reasoned medical opinion which concludes total disability is present, if the opinion is based on medically acceptable clinical and laboratory diagnostic techniques. A claimant must demonstrate that his respiratory or pulmonary condition prevents him from engaging in his "usual" coal mine employment or comparable and gainful employment". 20 C.F.R. §718.204(b)(2)(iv).

The physicians reports are set forth above. All the physicians agreed Claimant could not perform his usual coal mine employment based on his pulmonary condition. The physicians concluded Claimant has a moderate impairment (Dr. Potter, DX 12 and Dr. Baker, DX 14) or a moderately severe impairment (Dr. Repsher, EX 2) or a moderate to severe impairment (Dr. Rosenberg, EX 3). They all agreed he would be unable to perform the heavy manual labor required by his coal mine employment on a sustained basis. Therefore, I find Claimant has established total disability under the provisions of subsection 718.204(b)(2)(iv).

Upon consideration of all of the evidence of record, Claimant has established total disbility. I find the physicians reports which consider all the results on pulmonary testing to be more persuasive than the test results standing alone. Specifically, I note that the pulmonary specialists all relied upon the pulmonary function study results to support their finding of pulmonary disability despite the fact these results were variable. Nevertheless, the physicians relied upon the lowered FEV-1 values and the decreased FEV-1/FVC ratio values to support their finding that Claimant would be unable to perform his usual coal mine employment. Based on the physicians medical opinions, I find Claimant has established total disability under the provisions of Section 718.204.

The regulations also require that Claimant must establish that his total disability is due to pneumoconiosis as required by subsection 718.204(c). The Sixth Circuit requires that total disbility be "due at least in part" to pneumoconiosis. *Adams v. Director, OWCP*, 886 F.2d 818, 825 (6th Cir. 1989). In *Grundy Mining Co. v. Director, OWCP [Flynn]*, 353 F.3d 467 (6th Cir. 2003), the Sixth Circuit stated the following: The claimant bears the burden of proving total disability due to pneumoconiosis and . . . this causal link must be more then *de minimus*. . . .To satisfy the 'due to' requirement of the BLBA and its implementing regulations, a claimant must demonstrate by a preponderance of the evidence that pneumoconiosis is 'more than merely a speculative cause of his disability,' but instead 'is a contributing cause of some discernible conequence to his totally disabling respiratory impairment.' . . . To the extent that the claimant relies on a physician's opinion to make this showing, such statements cannot be vague or conclusory, but instead must reflect reasoned medical judgment.

Although Dr. Repsher and Dr. Rosenberg disagreed with Dr. Baker's conclusions regarding the etiology of Claimant's pulmonary disability, I find their opinions are entitled to less weight for the reasons set forth above. Dr. Baker's opinion that Claimant's pulmonary disability is due, at least in part, to his coal mine dust exposure is based on his findings on examination, pulmonary testing and medical articles that are consistent with the regulatory provisions. Under these circumstances, I find Dr. Baker's opinion that both coal mine dust exposure and cigarette smoking contributed to Claimant's pulmonary disability sufficient to establish total disability due to pneumoconiosis as required by subsection 718.204(c).

Entitlement

I find Claimant has established the presence of pneumoconiosis which arose out of his coal mine employment. In addition, Claimant has established total disability due to pneumoconiosis. Therefore, he is entitled to benefits under the Act.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed. 20 C.F.R. § 725.503(b). Based upon my review of the record, I cannot determine the onset of claimant's disability. Consequently, benefits shall commence November 1, 2002 the month that Claimant filed his application for benefits.

Attorney's Fee

Claimant's counsel has thirty days to submit an application for an attorney's fee. The application shall be prepared in strict accordance with 20 C.F.R. §§ 725.365 and 725.366. The application must be served on all parties, including the claimant, and proof of service must be filed with the application. The parties are allowed thirty days following service of the application to file objections to the fee application.

ORDER

Consol of Kentucky, Inc. is hereby ORDERED to pay to Claimant, McCray Amburgey, all benefits to which he is entitled under the Act, augmented by his reason of his two dependents, his wife Pauline and his son, Travis, commencing November 1, 2002.

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JOSEPH E. KANE
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).